momentum

Health4Me Chronic benefit application form

| mportant notes: You can register for health4mechronic@ | | | 0 29 03. Alte | rnatively, please subn | nit the completed and signed forr | n via email |
|---|-------------------------|------------------------------|-----------------------|----------------------------|--|-------------|
| 1: Patient's deta | ils | | | | | |
| Membership number | | | | Option name | е | |
| · Principal member's full nai | me(s) and surna | ame | 1 | • | | |
| Patient's full name(s) and | | | | | | |
| Patient's cellphone numbe | r | | | | | |
| Patient's address (for deliv | ery of chronic m | nedication) | | | | |
| | | | | | Postal code | |
| authorise my medical pra | ctitioner to furn | ish or disclose any facts re | lating to this a | pplication to Momentu | ım Health4Me. | |
| Name of signatory | | | | | | |
| Signature of member If minor, principal member must sign | | | | | Date D D M M Y | YYY |
| Chronic medication pro | • | eneral practitioner | | | | |
| New application | | Treatment update | | | | |
| Diagnosis (eg Hypertension) | ICD-10 code (eg J10) | Medication description | Strength (eg 25mg) | Directions (eg 1/Daily) | Date of diagnosis (month and year) Repeats (eg 6/12) | |
| | | | | | M M Y Y Y | |
| | | | | | M M Y Y Y | |
| | | | | | M M Y Y Y | |
| | D 10 | completed. We cannot pro | | | M M Y Y Y Y | |
| | | | | | from or medication that he/she is t | aking: |
| Supporting clinical info | ormation | | | | | |
| I. Relevant history - per | sonal (past) | | | | | |
| 2. Relevant history - fan | nily | | | | | |
| | | | | | | |
| | | | | | | |
| 3. Details of lifestyle and | d dietary progra | ımmes | | | | |
| . Details of lifestyle and | d dietary progra | nmmes | | | | |

Supporting clinical information (continued) Details of non-medication modalities to manage this patient Clinical assessment Weight kg cm BMI Waist circumference Height cm Smoking status Never Stopped Ave/day Ex Started Started Average per day 3 - 10 > 10 Present Blood pressure reading Initial Date Present Date 3: General practitioner's information Doctor's name(s) and surname Practice number Fax Contact number Email address Postal address Postal code I certify that the specific diagnosis indicated above relates to the medication that I have prescribed.

Date

For completion by the General practitioner (continued)

Momentum 268 West Avenue Centurion 0157 PO Box 7400 Centurion 0046 South Africa Call Centre 0860 10 29 03 health4me@momentum.co.za momentum.co.za Momentum Health4Me is administered by Momentum Health Solutions, registration number 1969/016884/07, a Juristic Representative on the Momentum Metropolitan Life Limited FSP license 6406 and the product is underwritten by Momentum Metropolitan Life Limited, registration number 1904/002186/06, an authorised insurer and financial services provider. Terms and conditions apply.

Signature of General Practitioner

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